Technical Assistance Document 9

Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation

Developed by
Arizona Department of Health Services
Division of Behavioral Health Services

Effective 05/01/06
Last Revised 04/17/06

Purpose

This Technical Assistance Document (TAD) is intended to provide a set of best practice guidelines for use by behavioral health prescribing clinicians, i.e., licensed physicians, certified nurse practitioners, and physician assistants, to assist prescribers in writing specific rationales for the combination of psychotropic medications (polypharmacy) used in the treatment of behavioral health disorders.

Psychiatric practitioners perform complex decision-making when choosing to prescribe or not to prescribe psychotropic medications to members. Documentation of that decision-making process, informed consent by the member, and the process of medical care is part of the member's medical record. Uniform application of documentation standards ensures that care can be transferred to other practitioners efficiently and effectively and promotes member understanding of his/her treatment.

ADHS/DBHS strongly recommends these guidelines be followed by all prescribing clinicians. Prescribing clinicians are also reminded that they must practice according to current policy/provider manual requirements related to informed consent and psychotropic medication use. T/RBHA monitoring procedures should seek to identify prescribing clinicians who do not adequately comply with these recommendations. ADHS/DBHS monitors the use of these guidelines through an annual independent case review process. Corrective action should be initiated as necessary.

Although the primary intent of this guidance document is to increase quality of care and consumer outcomes, secondary gains related to expenditures for pharmaceuticals are anticipated if the overall quantity of medication use is decreased.

Targeted Population(s)

All enrolled persons prescribed multiple psychotropic medications as part of their treatment.

Introduction

Current medical practice in the treatment of behavioral health disorders with psychotropic medications often involves the prescription of more than one and often multiple medications. Monotherapy, or the use of one psychotropic medication, is still the generally preferred mode of treatment for uncomplicated behavioral health disorders. Use of more than one medication in treatment, although common, does not necessarily improve efficacy or response to

treatment, may increase risk to the person being treated, and increases costs to the behavioral health system.

Although polypharmacy at times can often be an effective clinical intervention, it can also contribute to morbidity and mortality, especially in members with chronic disorders, the elderly, children, and adolescents. In behavioral health disorders, the greater the number of medications used, the greater the likelihood that adverse effects and drug-drug interactions may occur or be mistaken for psychiatric symptoms and the greater the likelihood that members will not be able to adhere to regimens or will make medication errors.

Therefore, it is essential when psychotropic medications are combined in the treatment of these disorders; the prescribing clinician clearly describes the target symptoms for each medication prescribed and provides a clear rationale for prescribing the combination of psychotropic medications.

In Provider Manual Section 3.15, Psychotropic Medications: Prescribing and Monitoring, ADHS defines "polypharmacy" as:

- The use of more than two psychotropic medications within the same class at the same time, other than for cross-tapering purposes, or
- The use of more than three psychotropic medications from different classes at the same time in the overall treatment of behavioral health disorders.

The "class" of psychotropic medications is broadly considered in applying the policy, e.g., all antidepressants, all antipsychotics, and all mood stabilizers. Attachment A provides a listing of the psychotropic medications by class as they apply to this definition of polypharmacy.

ADHS policy also requires that whenever medications are combined in the treatment of behavioral health disorders in a manner that meets the ADHS policy definition of polypharmacy, the prescribing clinician must clearly document (1) the rationale justifying the use of the particular combination of medications based upon the identified symptoms of the disorder(s) that the person is experiencing and (2) any additional likely/potential side effects to be experienced based on the particular medication combination. It is essential that the person also be provided with full informed consent for each psychotropic medication prescribed, as further clarified in Provider Manual Section 3.11, General and Informed Consent to Treatment, and Technical Assistance Document 8, Informed Consent for Psychotropic Medication Treatment.

The following guidelines are intended to assist prescribing clinicians with providing clear documentation of their reasoning process and justification when prescribing polypharmacy for the treatment of identified behavioral health disorders. These guidelines are also intended to improve the overall care and

treatment for behavioral health recipients. If a prescribing clinician cannot clearly outline a logical rationale for the combination of medications prescribed, the clinician should reconsider his/her prescription of multiple medications and consider other alternatives, including simplification of the person's medication regimen. The overall goal to provide appropriate and necessary psychotropic medication in the treatment of identified behavioral health disorders that is safe, effective, and efficient, so that the person may achieve the best possible outcomes.

Procedures

1. The prescription of psychotropic medication should always be based upon a professional behavioral health assessment by a competent, qualified, and licensed prescribing clinician. The assessment must include a detailed mental status examination.

   Treatment must always be individualized to respond to the person's identified needs. Whether or not psychotropic medications are prescribed, the clinician should always consider what non-medication services, including support services, should be provided. Individuals should be referred for any other recommended services that the prescribing clinician cannot personally provide.

   Identification and documentation of the target symptoms for psychotropic medication treatment provides a reliable basis for communicating an understanding of why these medications are prescribed for the person. An acceptable description of target symptoms is not just a notation of the DSM-IV TR diagnosis. For each psychotropic medication prescribed, the prescribing clinician must provide written documentation of the specific target symptoms for the use of the medication. In order to provide an adequate rationale for the combination of psychotropic medications, the prescribing clinician must first describe and document the target symptoms identified for the use of each medication prescribed. Documentation of the target symptoms must briefly and specifically describe the symptoms the person is experiencing and which are to be addressed with use of the specific medication being prescribed.

   Some examples of specific target symptom descriptions are:
   a. Citalopram is being prescribed for treatment of Major Depressive Disorder. Target symptoms include: marked depressed mood, frequent suicidal ideation, and marked loss of energy.
   b. Paroxetine is being prescribed for treatment of post-traumatic stress disorder (PTSD). Target symptoms include: nightmares of the traumatic event and irritable/angry mood.

c. Sertraline is being prescribed for treatment of obsessive-compulsive disorder (OCD). Target symptoms include: frequent obsessions of contamination with germs and compulsive hand washing.
d. Ziprasidone is being prescribed for treatment of Schizophrenia, Paranoid Type. Target symptoms include: derogatory auditory hallucinations, delusions of having an electronic device in the brain, and tangential thought processes.
e. Valproic Acid is being prescribed for treatment of Bipolar Disorder, Manic Episode. Target symptoms include: little need for sleep, verbosity, and markedly pressured speech.
f. Lorazepam is being prescribed for treatment of Generalized Anxiety Disorder. Target symptoms include: persistent tremor, unable to fall or stay asleep, and irritable/anxious mood.

2. Clear documentation of the target symptoms for each medication and the rationale for prescribing combinations of medications should provide a solid basis for identifying the specific outcomes of psychotropic medication treatment. Positive and/or negative outcomes can be easily tracked when specific target symptoms have been identified.

3. Progress notes with clear documentation, as demonstrated above, are useful for both the person receiving treatment and prescribing clinicians because they provide a record of treatment and treatment response for all medications prescribed. Because providers may change, clearly documented progress notes are essential in maintaining a clear written record of the reasons specific medications or medication combinations were used and should assist new clinicians in providing the best care possible for the person. Clearly documented progress notes should help to avoid unnecessary medication changes or repeat trials of previously tried treatment regimens, and should be used to inform the person about his/her individualized medication treatment and response to treatment.

   Clearly documented progress notes should also help to reduce potential legal liability concerns, as solid documentation of a clinician's justification can be provided to address any such concerns.

4. Specific rationales for the combined use of regularly prescribed psychotropic medications must clearly describe the reasons why the particular combination of medications is being prescribed. The rationale should be responsive to and correspond with the identified person's need for combined medication treatment. Rationales for polypharmacy and medication changes may include lack of full response (need to augment), patient preference, intolerable side effects of one of the medications, diagnosis changes, evidence-based practice, adverse effects, prior response, etc.

Some examples of specific rationales for the combined use of psychotropic medications are:

a. Symptoms of mania have not adequately responded to Lithium alone. Risperidone is added to target continued manic symptoms, including grandiosity and pressured speech (need to augment treatment);
b. Add Valproic Acid to Olanzapine due to need for rapid resolution of extreme psychotic symptoms, as supported by evidenced-based practice;
c. Add Topiramate to Olanzapine due to excessive weight gain (intolerable side effect);
d. Add Hydroxyzine prn for agitation to Clonazepam due to patient stating "it is the only thing that has ever worked when I am this anxious" (patient preference);
e. Add Fluoxetine, with its long half-life, for one week while patient is at the end of a Venlafaxine taper, due to severe serotonin discontinuation syndrome (adverse effect);
f. Add Clonazepam for new onset panic disorder (diagnosis change); and
g. Methylphenidate (Concerta) and Dextro-amphetamine are being combined, as Concerta alone does not adequately treat afternoon and evening hyperactivity symptoms.

5. Prescribing clinician practices are quite variable and are related to the person's individual situation, the referral source and the setting in which the person is being treated. Whenever the person, who is being initially referred for psychotropic medication treatment, presents with one or more medications already prescribed by another clinician, the clinician should only prescribe continuation of previously prescribed medications based upon his/her professional medical judgment. During an initial appointment, the prescribing clinician may not be able to complete a full assessment and may need to continue previously prescribed medications.

   An acceptable rationale for continuing a combination of medications prescribed by another clinician may be as follows:

   > "Client is comfortable with previously prescribed medications, experiences no side effects and no serious safety risks of continuing current medications have been identified."

   By the second visit, the prescribing clinician must provide a more specific rationale based upon the person's symptoms.

   If a prescribing clinician is filling-in for the regular prescriber, it is recommended that current medication combinations be continued until the regular prescriber returns, unless there is clearly (1) a less than optimal

response to treatment, (2) significant side effects, or (3) identified risks due to continuation of the prescribed treatment.

Prescribing clinicians who are new to the Regional Behavioral Health Authority (RBHA) system should receive a brief orientation to Arizona Department of Health Services (ADHS) and RBHA requirements, including exposure to these guidelines and documentation examples.

6. Prescribing clinicians who are treating persons with complex or specialized behavioral health needs (e.g., children in foster care, developmentally disabled individuals, and persons with complex medical conditions) may need appointment schedules that are flexible, adaptable, and expanded to a timeframe that will better serve and respond to the person and his/her special needs. The appointment-time length for prescribing clinicians should not be rigidly maintained.

Technical Assistance Document (TAD) #9
Desktop Guide

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- Key elements to remember about this best practice:
  - Intra-class Polypharmacy: more than 2 medications in same class at same time, other than when-cross-tapering
  - Inter-class Polypharmacy: more than 3 medications from different classes at same time
  - Document rationale addressing why combination is felt to be necessary
  - Document specific target symptoms being addressed with each medication
  - Document additional likely side effects based on this combination of medications
  - Obtain informed consent
  - Ask self: "Is this treatment safe, effective, and efficient?"
  - Consider non-medication treatments which may be beneficial; refer for services if indicated
  - Write legibly
  - Consider need for longer and/or more frequent appointments

- Benefits of using this best practice:
  - New prescribers know what you were thinking
  - Better consumer understanding of medications
  - Decrease in use of polypharmacy
  - Decreased medication side effects and drug-drug interactions
  - Increased medication compliance due to less complicated medication regimens
  - Potential financial benefit due to decreased medication use
  - Strong documentation reduces potential legal liability concerns

Pharmaceutical Classifications:

Intra-class: medications within the same class and/or sub-class listed below (ex: Haldol + Risperdal + Thorazine are considered intra-class polypharmacy)

Inter-class: medications from different classes (ex: Haldol + Wellbutrin + Prozac + Dapakote are considered inter-class polypharmacy)

Class	Sub-Class	Medications
Antipsychotics	Typical Antipsychotics (First Generation)	Haloperidol (Haldol) Thiothixene (Navane) Molindone (Moban) Loxapine (Loxitane) Chlorpromazine (Thorazine) Pimozide (Orap) Fluphenazine (Prolixin) Thioridazine (Mellaril) Perphenazine (Trilafon) Mesoridazine (Serentil) Trifluoperazine
	Atypicals (Second Generation)	Clozapine (Clozaril, FazoClo ODT) Risperidone (Risperdal) Olanzapine (Zyprexa) Ziprasidone (Geodon) Quetiapine (Seroquel) Aripiprazole (Abilify)
Antidepressants	Tricyclic Antidepressants	Imipramine (Tofranil) Desipramine (Norpramin) Nortriptyline (Pamelor, Aventyl) Protriptyline (Vivactil) Trimipramine (Surmontil) Doxepin (Sinequan) Amitriptyline Clomipramine (Anafranil)

	Heterocyclic Antidepressants	Bupropion (Wellbutrin, Zyban) Mirtazapine (Remeron) Amoxapine (Ascendin)
	SSRIs	Fluoxetine (Prozac) Paroxetine (Paxil) Citalopram (Celexa) Escitalopram (Lexapro) Sertraline (Zoloft) Fluvoxamine (Luvox)
	SNRIs	Duloxetine (Cymbalta) Venlafaxine (Effexor)
	MAOIs	Phenelzine Tranylcypromine
	Others	Nefazadone (Serzone) Trazodone (Desyrel)
Psycho-Stimulants/ ADHD Medications	Amphetamine/Dextroamphetamine Agents	Adderall, Dexedrine
	Methylphenidate/ Dexmethyl-phenidate Agents	Concerta, Metadate, Methylin, Ritalin, Focalin
	Other	Pemoline (Cylert) Atomoxetine (Strattera) Modafinil (Provigil)
Mood Stabilizers	Lithium Agents	Eskalith Lithobid
	Anticonvulsants	Valproic Acid/Divalproex Sodium (Depakote, Depakene) Carbamazepine (Carbatrol, Equetro, Tegretol) Oxcarbazepine (Trileptal) Lamotrigene (Lamictal) Topiramate (Topamax) Gabapentin (Neurontin) Levetiracetam (Keppra) Tiagabine (Gabitril) Clonazepam (Klonopin)

Sedatives and Hypnotics	Benzodiazepines	Diazepam (Valium) Lorazepam (Ativan) Triazolam (Halcion) Alprazolam (Xanax, Niravam) Clonazepam (Klonopin) Chlordiazepoxide (Librium) Flurazepam (Dalmane) Temazepam (Restoril) Oxazepam (Serax) Estazolam (Prosom) Clorazepate (Tranxene)
	Miscellaneous Sedatives and Hypnotics	Hydroxyzine (Vistaril, Atarax) Zolpidem (Ambien) Zaleplon (Sonata) Eszopiclone (Lunesta)
	Barbiturates	Pentobarbital (Nembutal) Secobarbital (Seconal) Amobarbital
	Other	Chloral Hydrate Buspirone (BuSpar)
Medications for Substance Abuse and Dependence Treatment		Methadone (Methadose, Dolophine) Buprenorphine (Buprenex, Subutex) Naloxone (Narcan) Disulfuram (Antabuse) Acamprosate (Campral) Naltrexone (ReVia) Ondansetron (Zofran)

Anti-Parkinsons and Autonomic Medications	Anticholinergics	Benztropine (Cogentin) Trihexyphenadil (Artane) Hydroxyzine (Vistaril, Atarax) Diphenhydramine (Benadryl) Cyproheptadine
	Dopaminergics	Amantadine (Symmetrel) Pramipexole (Miraprex)
	MAOIs	Selegiline (Eldepryl)
	Cardiovascular	Propranolol (Inderal) Clonidine (Catapres) Guanfacine (Tenex)